Mail To:

E.D.S. FEDERAL CORPORATION Prior Authorization Unit Suite 88 6406 Bridge Road Madison, WI 53784-0088

B. Is the recipient confined to place of residence?

C. Is a primary care giver available?

PA/HHSA

PRIOR AUTHORIZATION HOME HEALTH SERVICES ATTACHMENT

- 1. Complete this form
- 2. Attach to PA/RF (Prior Authorization Request Form)
- 3. Mail to EDS

NAME PERFORMING PROVIDER'S MEDICAL PERFORMING PROVIDER'S TELEPHONE NUMBER 10 REFERRING PROVIDER'S NAME REFERRING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	RECIPIENT INFORMATION					
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ASSISTANCE PROVIDER NUMBER						
ASSISTANCE PROVIDER NUMBER				220112520		
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d recipient history relative to the service requested: (including mobility, independen cial problems, etc.)		history relative to the	ASSISTANCI	E PROVIDER NUI	MBER 	ependen

☐ Yes

□ No

□ No

Explain:

D. Identify Home Health Aide services to be provided as they relate to the recipient's medical condition (be specific): (Include hours per day/days per week)

☐ Yes

F. How long have requested service(s) been provided? G. Identify the estimated duration of need: H. Indicate progress/status since care was initiated or last authorized, and estimate the need for continued service: THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).	Ε.	Identify the nursing services to be provided as they relate to the recipient's medical condition (be specific): (Include hours per day/days per week)	
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